**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

IMS EXPERTS LLC
120 N MAIN ST
MANSFIELD TX 76063

**Respondent Name**
AMERICAN ZURICH INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-13-1312-01

**MFDR Date Received**
JANUARY 25, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The charges should be allowed for the following reason(s): …Notice of Utilization Review Finds dated August 23rd, 2012 ODG state: Lumbar supports are treatments recommended as an option for post operative treatment for patients or for patients with documented instability…Forte Authorization for Requested Services dated 10/02/12, authorizes durable medical equipment purchase of a lumbar brace. Authorization number 1132844F O…"

**Amount in Dispute:** $1,500.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "COMES NOW AMERICAN ZURICH INSURANCE COMPANY, Carrier, and files it Supplemental Response to IMS Expert's Medical Fee Dispute Resolution Request. Carrier has reconsidered its position and processed the invoice of IMS Experts for payment. As a result, medical fee dispute resolution is not required."

**Response Submitted by:** Galloway, Johnson, Tompkins, Burr & Smith, 1301 McKinney, Ste. 1400, Houston, TX 77010

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 6, 2012 | HCPCS Code L0637 – Lumbar-sacral Orthosis | $1,500.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.

**Issues**

1. Did the respondent maintain denial for timely filing?
2. Was the requestor reimbursed for the durable medical equipment?

**Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the respondent finds that the insurance carrier has reconsidered the charges and issued payment for the durable medical equipment in dispute. The respondent also submitted a copy of the record of payment supporting payment has been made. For that reason the denial code, "29 – The time limit for filing has expired" is not supported.
2. In accordance with 28 Texas Administrative Code §134.203 (d)The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:(1)125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. The calculations for this HCPCS code is as follows:
   - HCPCS Code 0637 - $1,104.80 x 125% = $1,381.00

   The respondent issued payment in the amount of $1,414.15 on February 19, 2013. Per the record of payment the payment cleared the bank on March 6, 2013. Therefore, the requestor has been reimbursed and no further payment is due.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has been properly reimbursed.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | September 16, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.